Town of Merrimac
New Employee Form
(Full-Time)

Employee #: _____ **Name: _____**

Address: _____ **Department: _____(____)**

_____ **Position: _____**

Phone: (_____) _____- _____ **Date of Employment: _____/_____/_____**

SSN: _____-_____-_____ **Date of Birth: _____/_____/_____**

Marital Status: _____ **Emergency Contact: _____**

Rate/Hour: $_____ Weekly Hours: _____ **Emergency Phone: (_____) _____- _____**

Please complete the attached forms:

- **W-4 Employee Withholding Allowance Certificate:**
  The I.R.S. requires us to obtain your name and social security number exactly as they appear on your Social Security Card. Please show your Social Security Card for verification.
- **I-9 U.S. Department of Justice - Employment Eligibility Verification:**
  This form verifies your identity and employment authorization to work in the United States. Instructions are included with the form along with the Lists of Acceptable Documents. Original documents are required.
- **Essex Regional Retirement Board:** Make sure to fill out completely and return with required documents. You **must** provide a copy of your birth certificate for enrollment. **Note:** If you chose **"Option D"** on the beneficiary selection page, you **must** furnish a copy of the beneficiary's birth certificate. If the beneficiary is your spouse, you **must** also provide a copy of the marriage certificate.
- **MIIA:** For health, dental, and vision insurance options, please visit **http://townofmerrimac.com/426/Employee-Resources**
  - Complete **Health Insurance Responsibility Disclosure Form** if you decline to participate in the health insurance plan.
- **Form SSA-1945:** Earnings from your employment are not covered under Social Security.
- **Boston Mutual Life Insurance (OPTIONAL):** $10,000 Life and Accidental Death and Dismemberment insurance is available.
- **Boston Life Insurance Co. Authorization to Obtain Information for Underwriting:**
  If you elect to have Life with AD&D insurance, we must obtain your authorization for an investigative consumer report.
- **Refusal of Insurance:** This form must be completed if you elect not to sign up for Life and AD&D.
- **Salary Redirection Agreement:** This form must be completed if you elect to have your insurance deducted on a pretax basis.
- **Summary of the Conflict-of-Interest Law for Municipal Employees and Online Ethics Training:** Employees must complete both online ethics trainings, then email certificates to selectmen@townofmerrimac.com or print and submit them with your employment paperwork. The website is **https://www.mass.gov/how-to/complete-the-conflict-of-interest-law-education-requirements**
- **Pre-employment Physical and Screening:** Must be completed and received by payroll dept. PRIOR to start date. Please schedule at your convenience with Amesbury Health Center, 24 Morrill Place, Amesbury, MA 978-834-8190
- **Direct Deposit:** Your paycheck will be deposited directly into the bank account(s) of your choice. Please provide a voided check.
- **Paperless Pay Stubs:** Provide your email address to select this option_____
- **Deferred Compensation Plan and Supplemental Insurance (OPTIONAL):** For SMART plan and AFLAC benefit information, please visit **http://townofmerrimac.com/426/Employee-Resources** for information.

By signing below, employee agrees that they have received a copy of the "Personnel Policies and Procedures." Which is available online at **http://townofmerrimac.com/426/Employee-Resources**

_____ _____/_____/_____

Employee Signature Date

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

Instructions for Form I-9, Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Anti-Discrimination Notice. It is illegal to discriminate against work-authorized individuals in hiring, firing, recruitment or referral for a fee, or in the employment eligibility verification (Form I-9 and E-Verify) process based on that individual's citizenship status, immigration status or national origin. Employers CANNOT specify which document(s) the employee may present to establish employment authorization. The employer must allow the employee to choose the documents to be presented from the Lists of Acceptable Documents, found on the last page of Form I-9. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination. For more information, contact the Immigrant and Employee Rights Section (IER) in the Department of Justice's Civil Rights Division at **https://www.justice.gov/ier**.

Who is the Purpose of This Form?

Employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document verification of the identity and employment authorization of each new employee (both citizen and noncitizen) hired after November 27, 2011.

General Instructions

Both employers and employees are responsible for completing their respective sections of Form I-9. For the purpose of completing this form, the term "employer" means all employers, including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors, as defined in section 3 of the Migrant and Seasonal Agricultural Worker Protection Act, Public Law 97-470 (29 U.S.C. 1802). An "employee" is a person who performs labor or services in the United States for an employer in return for wages or other remuneration. The term "Employee" does not include those who do not receive any form of remuneration (volunteers), independent contractors or those engaged in certain casual domestic employment. Form I-9 has three sections. Employees complete Section 1. Employers complete Section 2 and, when applicable, Section 3. Employers may be fined if the form is not properly completed. See 8 USC § 1324a and 8 CFR § 274a.10. Individuals may be prosecuted for knowingly and willfully entering false information on the form. Employers are responsible for retaining completed forms. **Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).**

These instructions will assist you in properly completing Form I-9. The employer must ensure that all pages of the instructions and Lists of Acceptable Documents are available, either in print or electronically, to all employees completing this form. When completing the form on a computer, the English version of the form includes specific instructions for each field and drop-down lists for universally used abbreviations and acceptable documents. To access these instructions, move the cursor over each field or click on the question mark symbol ( ) within the field. Employers and employees can also access this full set of instructions at any time by clicking the Instructions button at the top of each page when completing the form on a computer that is connected to the Internet.

Employers and employees may choose to complete any or all sections of the form on paper or using a computer, or a combination of both. Forms I-9 obtained from the USCIS website are not considered electronic Forms I-9 under DHS regulations and, therefore, cannot be electronically signed. Therefore, regardless of the method you used to enter information into each field, you must print a hard copy of the form, then sign and date the hard copy by hand where required.

Employers can obtain a blank copy of Form I-9 from the USCIS website at https://www.uscis.gov/i-9. This form is in portable document format (.pdf) that is fillable and savable. That means that you may download it, or simply print out a blank copy to enter information by hand. You may also request paper Forms I-9 from USCIS.

Certain features of Form I-9 that allow for data entry on personal computers may make the form appear to be more than two pages. When using a computer, Form I-9 has been designed to print as two pages. Using more than one preparer and/or translator will add an additional page to the form, regardless of your method of completion. You are not required to print, retain or store the page containing the Lists of Acceptable Documents.

The form will also populate certain fields with N/A when certain user choices ensure that particular fields will not be completed. The Print button located at the top of each page that will print any number of pages the user selects. Also, the Start Over button located at the top of each page will clear all the fields on the form.

The Spanish version of Form I-9 does not include the additional instructions and drop-down lists described above. Employers in Puerto Rico may use either the Spanish or English version of the form. Employers outside of Puerto Rico must retain the English version of the form for their records, but may use the Spanish form as a translation tool. Additional guidance to complete the form may be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274) and on USCIS' Form I-9 website, I-9 Central.

Completing Section 1: Employee Information and Attestation

You, the employee, must complete each field in Section 1 as described below. Newly hired employees must complete and sign Section 1 no later than the first day of employment. Section 1 should never be completed before you have accepted a job offer.

Entering Your Employee Information

Last Name *(Family Name)*: Enter your full legal last name. Your last name is your family name or surname. If you have two last names or a hyphenated last name, include both names in the Last Name field. *Examples of correctly entered last names include: De La Cruz, O'Neill, Garcia Lopez, Smith-Johnson, Nguyen.* If you only have one name, enter it in this field, then enter "Unknown" in the First Name field. You may not enter "Unknown" in both the Last Name field and the First Name field.

First Name *(Given Name)*: Enter your full legal first name. Your first name is your given name. *Some examples of correctly entered first names include: Jessica, John-Paul, Tae Young, D'Shaun. Mai.* If you only have one name, enter it in the Last Name field, then enter "Unknown" in this field. You may not enter "Unknown" in both the First Name field and the Last Name field.

Middle Initial: Your middle initial is the first letter of your second given name, or the first letter of your middle name, if any. If you have more than one middle name, enter the first letter of your first middle name. If you do not have a middle name, enter N/A in this field.

Other Last Names Used: Provide all other last names used, if any (e.g., maiden name). Enter N/A if you have not used other last names. For example, if you legally changed your last name from Smith to Jones, you should enter the name Smith in this field.

Address (*Street Name and Number*): Enter the street name and number of the current address of your residence. If you are a border commuter from Canada or Mexico, you may enter your Canada or Mexico address in this field. If your residence does not have a physical address, enter a description of the location of your residence, such as "3 miles southwest of Anytown post office near water tower."

Apartment: Enter the number(s) or letter(s) that identify(ies) your apartment. If you do not live in an apartment, enter N/A.

City or Town: Enter your city, town or village in this field. If your residence is not located in a city, town or village, enter your county, township, reservation, etc., in this field. If you are a border commuter from Canada, enter your city and province in this field. If you are a border commuter from Mexico, enter your city and state in this field.

State: Enter the abbreviation of your state or territory in this field. If you are a border commuter from Canada or Mexico, enter your country abbreviation in this field.

ZIP Code: Enter your 5-digit ZIP code. If you are a border commuter from Canada or Mexico, enter your 5- or 6-digit postal code in this field.

Date of Birth (*mm/dd/yyyy*): Enter your date of birth as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 1980 as 01/08/1980.

U.S. Social Security Number: Providing your 9-digit Social Security number is voluntary on Form I-9 unless your employer participates in E-Verify. If your employer participates in E-Verify and:

1. You have been issued a Social Security number, you must provide it in this field; or
2. You have applied for, but have not yet received a Social Security number, leave this field blank until you receive a Social Security number.

Employee's E-mail Address (*Optional*): Providing your e-mail address is optional on Form I-9, but the field cannot be left blank. To enter your e-mail address, use this format: name@site.domain. One reason Department of Homeland Security (DHS) may e-mail you is if your employer uses E-Verify and DHS learns of a potential mismatch between the information provided and the information in government records. This e-mail would contain information on how to begin to resolve the potential mismatch. You may use either your personal or work e-mail address in this field. Enter N/A if you do not enter your e-mail address.

Employee's Telephone Number (*Optional*): Providing your telephone number is optional on Form I-9, but the field cannot be left blank. If you enter your area code and telephone number, use this format: 000-000-0000. Enter N/A if you do not enter your telephone number.

Attesting to Your Citizenship or Immigration Status

You must select one box to attest to your citizenship or immigration status.

1. **A citizen of the United States.**

2. **A noncitizen national of the United States:** An individual born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

3. **A lawful permanent resident**: An individual who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant. This term includes conditional residents. Asylees and refugees should not select this status, but should instead select "An Alien authorized to work" below.

   If you select "lawful permanent resident," enter your 7- to 9-digit Alien Registration Number (A-Number), including the "A," or USCIS Number in the space provided. When completing this field using a computer, use the dropdown provided to indicate whether you have entered an Alien Number or a USCIS Number. At this time, the USCIS Number is the same as the A-Number without the "A" prefix.

4. **An alien authorized to work**: An individual who is not a citizen or national of the United States, or a lawful permanent resident, but is authorized to work in the United States.

   If you select this box, enter the date that your employment authorization expires, if any, in the space provided. In most cases, your employment authorization expiration date is found on the document(s) evidencing your employment authorization. Refugees, asylees and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, and other aliens whose employment authorization does not have an expiration date should enter N/A in the Expiration Date field. In some cases, such as if you have Temporary Protected Status, your employment authorization may have been automatically extended; in these cases, you should enter the expiration date of the automatic extension in this space.

   Aliens authorized to work must enter one of the following to complete Section 1:

   1. Alien Registration Number (A-Number)/USCIS Number; or
   2. Form I-94 Admission Number; or
   3. Foreign Passport Number and the Country of Issuance.

   Your employer may not ask you to present the document from which you supplied this information.

   Alien Registration Number/USCIS Number: Enter your 7- to 9-digit Alien Registration Number (A-Number), including the "A," or your USCIS Number in this field. At this time, the USCIS Number is the same as your A-Number without the "A" prefix. When completing this field using a computer, use the dropdown provided to indicate whether you have entered an Alien Number or a USCIS Number. If you do not provide an A-Number or USCIS Number, enter N/A in this field then enter either a Form I-94 Admission Number, or a Foreign Passport and Country of Issuance in the fields provided.

   Form I-94 Admission Number: Enter your 11-digit I-94 Admission Number in this field. If you do not provide an I-94 Admission Number, enter N/A in this field, then enter either an Alien Registration Number/USCIS Number or a Foreign Passport Number and Country of Issuance in the fields provided.

   Foreign Passport Number: Enter your Foreign Passport Number in this field. If you do not provide a Foreign Passport Number, enter N/A in this field, then enter either an Alien Number/USCIS Number or a I-94 Admission Number in the fields provided.

   Country of Issuance: If you entered your Foreign Passport Number, enter your Foreign Passport's Country of Issuance. If you did not enter your Foreign Passport Number, enter N/A.

Signature of Employee: After completing Section 1, sign your name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. By signing this form, you attest under penalty of perjury (28 U.S.C. § 1746) that the information you provided, along with the citizenship or immigration status you selected, and all information and documentation you provide to your employer, is complete, true and correct, and you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or using false documentation when completing this form. Further, falsely attesting to U.S. citizenship may subject employees to penalties, removal proceedings and may adversely affect an employee's ability to seek future immigration benefits. If you cannot sign your name, you may place a mark in this field to indicate your signature. Employees who use a preparer or translator to help them complete the form must still sign or place a mark in the Signature of Employee field on the printed form.

If you used a preparer, translator, and other individual to assist you in completing Form I-9:

- Both you and your preparer(s) and/or translator(s) must complete the appropriate areas of Section 1, and then sign Section 1. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to sign these fields. You and your preparer(s) and/or translator(s) also should review the instructions for **Completing the Preparer and/or Translator Certification** below.
- If the employee is a minor (individual under 18) who cannot present an identity document, the employee's parent or legal guardian can complete Section 1 for the employee and enter "minor under age 18" in the signature field. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to enter this information. The minor's parent or legal guardian should review the instructions for Completing the Preparer and/or Translator Certification below. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on completion of Form I-9 for minors. If the minor's employer participates in E-Verify, the employee must present a list B identity document with a photograph to complete Form I-9.
- If the employee is a person with a disability (who is placed in employment by a nonprofit organization, association or as part of a rehabilitation program) who cannot present an identity document, the employee's parent, legal guardian or a representative of the nonprofit organization, association or rehabilitation program can complete Section 1 for the employee and enter "Special Placement" in this field. If Section 1 was completed on a form obtained from the USCIS website, the form must be printed to enter this information. The parent, legal guardian or representative of the nonprofit organization, association or rehabilitation program completing Section 1 for the employee should review the instructions for Completing the Preparer and/or Translator Certification below. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on completion of Form I-9 for certain employees with disabilities.

Today's Date: Enter the date you signed Section 1 in this field. Do not backdate this field. Enter the date as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014. A preparer or translator who assists the employee in completing Section 1 may enter the date the employee signed or made a mark to sign Section 1 in this field. Parents or legal guardians assisting minors (individuals under age 18) and parents, legal guardians or representatives of a nonprofit organization, association or rehabilitation program assisting certain employees with disabilities must enter the date they completed Section 1 for the employee.

Completing the Preparer and/or Translator Certification

If you did not use a preparer or translator to assist you in completing Section 1, you, the employee, must check the box marked **I did not use a Preparer or Translator**. If you check this box, leave the rest of the fields in this area blank.

If one or more preparers and/or translators assist the employee in completing the form using a computer, the preparer and/or translator must check the box marked **"A preparer(s) and/or translator(s) assisted the employee in completing Section 1"**, then select the number of Certification areas needed from the dropdown provided. Any additional Certification areas generated will result in an additional page. The Form I-9 Supplement, Section 1 Preparer and/or Translator Certification, can be separately downloaded from the USCIS Form I-9 webpage, which provides additional Certification areas for those completing Form I-9 using a computer who need more Certification areas than the 5 provided or those who are completing Form I-9 on paper. The first preparer and/or translator must complete all the fields in the Certification area on the same page the employee has signed. There is no limit to the number of preparers and/or translators an employee can use, but each additional preparer and/or translator must complete and sign a separate Certification area. Ensure the employee's last name, first name and middle initial are entered at the top of any additional pages. The employer must ensure that any additional pages are retained with the employee's completed Form I-9.

Signature of Preparer or Translator: Any person who helped to prepare or translate Section 1of Form I-9 must sign his or her name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. The Preparer and/or Translator Certification must also be completed if "Individual under Age 18" or "Special Placement" is entered in lieu of the employee's signature in Section 1.

Today's Date: The person who signs the Preparer and/or Translator Certification must enter the date he or she signs in this field on the printed form. Do not backdate this field. Enter the date as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Last Name *(Family Name)*: Enter the full legal last name of the person who helped the employee in preparing or translating Section 1 in this field. The last name is also the family name or surname. If the preparer or translator has two last names or a hyphenated last name, include both names in this field.

First Name (*Given Name*): Enter the full legal first name of the person who helped the employee in preparing or translating Section 1 in this field. The first name is also the given name.

Address (*Street Name and Number*): Enter the street name and number of the current address of the residence of the person who helped the employee in preparing or translating Section 1 in this field. Addresses for residences in Canada or Mexico may be entered in this field. If the residence does not have a physical address, enter a description of the location of the residence, such as "3 miles southwest of Anytown post office near water tower." If the residence is an apartment, enter the apartment number in this field.

City or Town: Enter the city, town or village of the residence of the person who helped the employee in preparing or translating Section 1 in this field. If the residence is not located in a city, town or village, enter the name of the county, township, reservation, etc., in this field. If the residence is in Canada, enter the city and province in this field. If the residence is in Mexico, enter the city and state in this field.

State: Enter the abbreviation of the state, territory or country of the preparer or translator's residence in this field.

ZIP Code: Enter the 5-digit ZIP code of the residence of the person who helped the employee in preparing or translating Section 1 in this field. If the preparer or translator's residence is in Canada or Mexico, enter the 5- or 6-digit postal code.

Presenting Form I-9 Documents

Within 3 business days of starting work for pay, you must present to your employer documentation that establishes your identity and employment authorization. For example, if you begin employment on Monday, you must present documentation on or before Thursday of that week. However, if you were hired to work for less than 3 business days, you must present documentation no later than the first day of employment.

Choose which unexpired document(s) to present to your employer from the Lists of Acceptable Documents. An employer cannot specify which document(s) you may present from the Lists of Acceptable Documents. You may present either one selection from List A or a combination of one selection from List B and one selection from List C. Some List A documents, which show both identity and employment authorization, are combination documents that must be presented together to be considered a List A document: for example, the foreign passport together with a Form I-94 containing an endorsement of the alien's nonimmigrant status and employment authorization with a specific employer incident to such status. List B documents show identity only and List C documents show employment authorization only. If your employer participates in E-Verify and you present a List B document, the document must contain a photograph. If you present acceptable List A documentation, you should not be asked to present, nor should you provide, List B and List C documentation. If you present acceptable List B and List C documentation, you should not be asked to present, nor should you provide, List A documentation. If you are unable to present a document(s) from these lists, you may be able to present an acceptable receipt. Refer to the Receipts section below.

Your employer must review the document(s) you present to complete Form I-9. If your document(s) reasonably appears to be genuine and to relate to you, your employer must accept the documents. If your document(s) does not reasonably appear to be genuine or to relate to you, your employer must reject it and provide you with an opportunity to present other documents from the Lists of Acceptable Documents. Your employer may choose to make copies of your document(s), but must return the original(s) to you. Your employer must review your documents in your physical presence.

Your employer will complete the other parts of this form, as well as review your entries in Section 1. Your employer may ask you to correct any errors found. Your employer is responsible for ensuring all parts of Form I-9 are properly completed and is subject to penalties under federal law if the form is not completed correctly.

Minors (individuals under age 18) and certain employees with disabilities whose parent, legal guardian or representative completed Section 1 for the employee are only required to present an employment authorization document from List C. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on minors and certain individuals with disabilities.

Receipts

If you do not have unexpired documentation from the Lists of Acceptable Documents, you may be able to present a receipt(s) in lieu of an acceptable document(s). New employees who choose to present a receipt(s) must do so within three business days of their first day of employment. If your employer is reverifying your employment authorization, and you choose to present a receipt for reverification, you must present the receipt by the date your employment authorization expires. Receipts are not acceptable if employment lasts fewer than three business days.

There are three types of acceptable receipts:

1. A receipt showing that you have applied to replace a document that was lost, stolen or damaged. You must present the actual document within 90 days from the date of hire or, in the case of reverification, within 90 days from the date your original employment authorization expires.
2. The arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and a photograph of the individual. You must present the actual Permanent Resident Card (Form I-551) by the expiration date of the temporary I-551 stamp, or, if there is no expiration date, within 1 year from the date of admission.
3. The departure portion of Form I-94/I-94A with a refugee admission stamp. You must present an unexpired Employment Authorization Document (Form I-766) or a combination of a List B document and an unrestricted Social Security Card within 90 days from the date of hire or, in the case of reverification, within 90 days from the date your original employment authorization expires.

Receipts showing that you have applied for an initial grant of employment authorization, or for renewal of your expiring or expired employment authorization, are not acceptable.

Completing Section 2: Employer or Authorized Representative Review and Verification

You, the employer, must ensure that all parts of Form I-9 are properly completed and may be subject to penalties under federal law if the form is not completed correctly. Section 1 must be completed no later than the employee's first day of employment. You may not ask an individual to complete Section 1 before he or she has accepted a job offer. Before completing Section 2, you should review Section 1 to ensure the employee completed it properly. If you find any errors in Section 1, have the employee make corrections, as necessary and initial and date any corrections made.

You may designate an authorized representative to act on your behalf to complete Section 2. An authorized representative can be any person you designate to complete and sign Form I-9 on your behalf. You are liable for any violations in connection with the form or the verification process, including any violations of the employer sanctions laws committed by the person designated to act on your behalf.

You or your authorized representative must complete Section 2 by examining evidence of identity and employment authorization within 3 business days of the employee's first day of employment. For example, if an employee begins employment on Monday, you must review the employee's documentation and complete Section 2 on or before Thursday of that week. However, if you hire an individual for less than 3 business days, Section 2 must be completed no later than the first day of employment.

Entering Employee Information from Section 1

This area, titled, "Employee Info from Section 1" contains fields to enter the employee's last name, first name, middle initial exactly as he or she entered them in Section 1. This area also includes a Citizenship/Immigration Status field to enter the number of the citizenship or immigration status checkbox the employee selected in Section 1. These fields help to ensure that the two pages of an employee's Form I-9 remain together. When completing Section 2 using a computer, the number entered in the Citizenship/Immigration Status field provides drop-downs that directly relate to the employee's selected citizenship or immigration status.

Entering Documents the Employee Presents

You, the employer or authorized representative, must physically examine, in the employee's physical presence, the unexpired document(s) the employee presents from the Lists of Acceptable Documents to complete the Document fields in Section 2.

You cannot specify which document(s) an employee may present from these lists. If you discriminate in the Form I-9 process based on an individual's citizenship status, immigration status, or national origin, you may be in violation of the law and subject to sanctions such as civil penalties and be required to pay back pay to discrimination victims. A document is acceptable as long as it reasonably appears to be genuine and to relate to the person presenting it. Employees must present one selection from List A or a combination of one selection from List B and one selection from List C.

List A documents show both identity and employment authorization. Some List A documents are combination documents that must be presented together to be considered a List A document, such as a foreign passport together with a Form I-94 containing an endorsement of the alien's nonimmigrant status.

List B documents show identity only, and List C documents show employment authorization only. If an employee presents a List A document, do not ask or require the employee to present List B and List C documents, and vice versa. If an employer participates in E-Verify and the employee presents a List B document, the List B document must include a photograph.

If an employee presents a receipt for the application to replace a lost, stolen or damaged document, the employee must present the replacement document to you within 90 days of the first day of work for pay, or in the case of reverification, within 90 days of the date the employee's employment authorization expired. Enter the word "Receipt" followed by the title of the receipt in Section 2 under the list that relates to the receipt.

When your employee presents the replacement document, draw a line through the receipt, then enter the information from the new document into Section 2. Other receipts may be valid for longer or shorter periods, such as the arrival portion of Form I-94/ I-94A containing a temporary I-551 stamp and a photograph of the individual, which is valid until the expiration date of the temporary I-551 stamp or, if there is no expiration date, valid for one year from the date of admission.

Ensure that each document is an unexpired, original (no photocopies, except for certified copies of birth certificates) document. Certain employees may present an expired employment authorization document, which may be considered unexpired, if the employee's employment authorization has been extended by regulation or a Federal Register Notice. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) or I-9 Central for more guidance on these special situations.

Refer to the M-274 for guidance on how to handle special situations, such as students (who may present additional documents not specified on the Lists) and H-1B and H-2A nonimmigrants changing employers.

Minors (individuals under age 18) and certain employees with disabilities whose parent, legal guardian or representative completed Section 1 for the employee are only required to present an employment authorization document from List C. Refer to the M-274 for more guidance on minors and certain persons with disabilities. If the minor's employer participates in E-Verify, the minor employee also must present a List B identity document with a photograph to complete Form I-9.

You must return original document(s) to the employee, but may make photocopies of the document(s) reviewed. Photocopying documents is voluntary unless you participate in E-Verify. E-Verify employers are only required to photocopy certain documents. If you are an E-Verify employer who chooses to photocopy documents other than those you are required to photocopy, you should apply this policy consistently with respect to Form I-9 completion for all employees. For more information on the types of documents that an employer must photocopy if the employer uses E-Verify, visit E-Verify's website at www.everify.gov. For non-E-Verify employers, if photocopies are made, they should be made consistently for ALL new hires and reverified employees.

Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or another federal government agency. You must always complete Section 2 by reviewing original documentation, even if you photocopy an employee's document(s) after reviewing the documentation. Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. You are still responsible for completing and retaining Form I-9.

List A - Identity and Employment Authorization: If the employee presented an acceptable document(s) from List A or an acceptable receipt for a List A document, enter the document(s) information in this column. If the employee presented a List A document that consists of a combination of documents, enter information from each document in that combination in a separate area under List A as described below. All documents must be unexpired. If you enter document information in the List A column, you should not enter document information or N/A in the List B or List C columns. If you complete Section 2 using a computer, a selection in List A will fill all the fields in the Lists B and C columns with N/A.

Document Title: If the employee presented a document from List A, enter the title of the List A document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviation to enter the document title or issuing authority. If the employee presented a combination of documents, use the second and third Document Title fields as necessary.

Full name of List A Document	Abbreviations
U.S. Passport	U.S. Passport
U.S. Passport Card	U.S. Passport Card
Permanent Resident Card (Form I-551)	Perm. Resident Card (Form I-551)
Alien Registration Receipt Card (Form I-551)	Alien Reg. Receipt Card (Form I-551)
Foreign passport containing a temporary I-551 stamp	1. Foreign Passport 2. Temporary I-551 Stamp
Foreign passport containing a temporary I-551 printed notation on a machine-readable immigrant visa (MRIV)	1. Foreign Passport 2. Machine-readable immigrant visa (MRIV)
Employment Authorization Document (Form I-766)	Employment Auth. Document (Form I-766)
For a nonimmigrant alien authorized to work for a specific employer because of his or her status, a foreign passport with Form I/94/I-94A that contains an endorsement of the alien's nonimmigrant status	1. Foreign Passport, work-authorized non-immigrant 2. Form I-94/I94A 3. Form I-20 or Form DS-2019 Note: In limited circumstances, certain J-1 students may be required to present a letter from their Responsible Officer in order to work. Enter the document title, issuing authority, document number and expiration date from this document in the Additional Information field.
Passport from the Federated States of Micronesia (FSM) with Form I-94/I-94A	1. FSM Passport with Form I-94 2. Form I-94/I94A
Passport from the Republic of the Marshall Islands (RMI) with Form I-94/I94A	1. RMI Passport with Form I-94 2. Form I-94/I94A
Receipt: The arrival portion of Form I-94/I-94A containing a temporary I-551 stamp and photograph	Receipt: Form I-94/I-94A w/I-551 stamp, photo
Receipt: The departure portion of Form I-94/I-94A with an unexpired refugee admission stamp	Receipt: Form I-94/I-94A w/refugee stamp
Receipt for an application to replace a lost, stolen or damaged Permanent Resident Card (Form I-551)	Receipt replacement Perm. Res. Card (Form I-551)
Receipt for an application to replace a lost, stolen or damaged Employment Authorization Document (Form I-766)	Receipt replacement EAD (Form I-766)
Receipt for an application to replace a lost, stolen or damaged foreign passport with Form I-94/I-94A that contains an endorsement of the alien's nonimmigrant status	1. Receipt: Replacement Foreign Passport, work-authorized nonimmigrant 2. Receipt: Replacement Form I-94/I-94A 3. Form I-20 or Form DS-2019 (if presented)
Receipt for an application to replace a lost, stolen or damaged passport from the Federated States of Micronesia with Form I-94/I-94A	1. Receipt: Replacement FSM Passport with Form I-94 2. Receipt: Replacement Form I-94/I-94A
Receipt for an application to replace a lost, stolen or damaged passport from the Republic of the Marshall Islands with Form I-94/ I-94A	1. Receipt: Replacement RMI Passport with Form I-94 2. Receipt: Replacement Form I-94/I-94A

Issuing Authority: Enter the issuing authority of the List A document or receipt. The issuing authority is the specific entity that issued the document. If the employee presented a combination of documents, use the second and third Issuing Authority fields as necessary.

Document Number: Enter the document number, if any, of the List A document or receipt presented. If the document does not contain a number, enter N/A in this field. If the employee presented a combination of documents, use the second and third Document Number fields as necessary. If the document presented was a Form I-20 or DS-2019, enter the Student and Exchange Visitor Information System (SEVIS) number in the third Document Number field exactly as it appears on the Form I-20 or the DS-2019.

Expiration Date (*if any*) (*mm/dd/yyyy*): Enter the expiration date, if any, of the List A document. The document is not acceptable if it has already expired. If the document does not contain an expiration date, enter N/A in this field. If the document uses text rather than a date to indicate when it expires, enter the text as shown on the document, such as "D/S" (which means, "duration of status"). For a receipt, enter the expiration date of the receipt validity period as described above. If the employee presented a combination of documents, use the second and third Expiration Date fields as necessary. If the document presented was a Form I-20 or DS-2019, enter the program end date here.

List B - Identity: If the employee presented an acceptable document from List B or an acceptable receipt for the application to replace a lost, stolen, or destroyed List B document, enter the document information in this column. If a parent or legal guardian attested to the identity of an employee who is an individual under age 18 or certain employees with disabilities in Section 1, enter either "Individual under age 18" or "Special Placement" in this field. Refer to the Handbook for Employers: Guidance for Completing Form I-9 (M-274) for more guidance on individuals under age 18 and certain person with disabilities.

If you enter document information in the List B column, you must also enter document information in the List C column. If an employee presents acceptable List B and List C documents, do not ask the employees to present a List A document. If you enter document information in List B, you should not enter document information or N/A in List A. If you complete Section 2 using a computer, a selection in List B will fill all the fields in the List A column with N/A.

Document Title: If the employee presented a document from List B, enter the title of the List B document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviations to document the document title or issuing authority.

Full name of List B Document	Abbreviations
Driver's license issued by a State or outlying possession of the United States	Driver's license issued by state/territory
ID card issued by a State or outlying possession of the United States	ID card issued by state/territory
ID card issued by federal, state, or local government agencies or entities (Note: This selection does not include the driver's license or ID card issued by a State or outlying possession of the United States as described in B1 of the List of Acceptable Documents.)	Government ID
School ID card with photograph	School ID
Voter's registration card	Voter registration card
U.S. Military card	U.S. Military card
U.S. Military draft record	U.S. Military draft record
Military dependent's ID card	Military dependent's ID card
U.S. Coast Guard Merchant Mariner Card	USCG Merchant Mariner card
Native American tribal document	Native American tribal document
Driver's license issued by a Canadian government authority	Canadian driver's license
School record (for persons under age 18 who are unable to present a document listed above)	School record (under age 18)
Report card (for persons under age 18 who are unable to present a document listed above)	Report card (under age 18)
Clinic record (for persons under age 18 who are unable to present a document listed above)	Clinic record (under age 18)
Doctor record (for persons under age 18 who are unable to present a document listed above)	Doctor record (under age 18)
Hospital record (for persons under age 18 who are unable to present a document listed above)	Hospital record (under age 18)
Day-care record (for persons under age 18 who are unable to present a document listed above)	Day-care record (under age 18)
Nursery school record (for persons under age 18 who are unable to present a document listed above)	Nursery school record (under age 18)

Full name of List B Document	Abbreviations
Individual under age 18 endorsement by parent or guardian	Individual under Age 18
Special placement endorsement for persons with disabilities	Special Placement
Receipt for the application to replace a lost, stolen or damaged Driver's License issued by a State or outlying possession of the United States	Receipt: Replacement driver's license
Receipt for the application to replace a lost, stolen or damaged ID card issued by a State or outlying possession of the United States	Receipt: Replacement ID card
Receipt for the application to replace a lost, stolen or damaged ID card issued by federal, state, or local government agencies or entities	Receipt: Replacement Gov't ID
Receipt for the application to replace a lost, stolen or damaged School ID card with photograph	Receipt: Replacement School ID
Receipt for the application to replace a lost, stolen or damaged Voter's registration card	Receipt: Replacement Voter reg. card
Receipt for the application to replace a lost, stolen or damaged U.S. Military card	Receipt: Replacement U.S. Military card
Receipt for the application to replace a lost, stolen or damaged Military dependent's ID card	Receipt: Replacement U.S. Military dep. card
Receipt for the application to replace a lost, stolen or damaged U.S. Military draft record	Receipt: Replacement Military draft record
Receipt for the application to replace a lost, stolen or damaged U.S. Coast Guard Merchant Mariner Card	Receipt: Replacement Merchant Mariner card
Receipt for the application to replace a lost, stolen or damaged Driver's license issued by a Canadian government authority	Receipt: Replacement Canadian DL
Receipt for the application to replace a lost, stolen or damaged Native American tribal document	Receipt: Replacement Native American tribal doc
Receipt for the application to replace a lost, stolen or damaged School record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement School record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Report card (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Report card (under age 18)
Receipt for the application to replace a lost, stolen or damaged Clinic record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Clinic record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Doctor record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Doctor record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Hospital record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Hospital record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Day-care record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Day-care record (under age 18)
Receipt for the application to replace a lost, stolen or damaged Nursery school record (for persons under age 18 who are unable to present a document listed above)	Receipt: Replacement Nursery school record (under age 18)

Issuing Authority: Enter the issuing authority of the List B document or receipt. The issuing authority is the entity that issued the document. If the employee presented a document that is issued by a state agency, include the state as part of the issuing authority.

Document Number: Enter the document number, if any, of the List B document or receipt exactly as it appears on the document. If the document does not contain a number, enter N/A in this field.

Expiration Date (*if any*) (*mm/dd/yyyy*): Enter the expiration date, if any, of the List B document. The document is not acceptable if it has already expired. If the document does not contain an expiration date, enter N/A in this field. For a receipt, enter the expiration date of the receipt validity period as described in the Receipt section above.

List C - Employment Authorization: If the employee presented an acceptable document from List C, or an acceptable receipt for the application to replace a lost, stolen, or destroyed List C document, enter the document information in this column. If you enter document information in the List C column, you must also enter document information in the List B column. If an employee presents acceptable List B and List C documents, do not ask the employee to present a list A document. If you enter document information in List C, you should not enter document information or N/A in List A. If you complete Section 2 using a computer, a selection in List C will fill all the fields in the List A column with N/A.

Document Title: If the employee presented a document from List C, enter the title of the List C document or receipt in this field. The abbreviations provided are available in the dropdown when the form is completed on a computer. When completing the form on paper, you may choose to use these abbreviations or any other common abbreviations to document the document title or issuing authority. If you are completing the form on a computer, and you select an Employment authorization document issued by DHS, the field will populate with List C #7 and provide a space for you to enter a description of the documentation the employee presented. Refer to the M-274 for guidance on entering List C #7 documentation.

Full name of List C Document	Abbreviations
Social Security Account Number card without restrictions	(Unrestricted) Social Security Card
Certification of Birth Abroad (Form FS-545)	Form FS-545
Certification of Report of Birth (Form DS-1350)	Form DS-1350
Consular Report of Birth Abroad (Form FS-240)	Form FS-240
Original or certified copy of a U.S. birth certificate bearing an official seal	Birth Certificate
Native American tribal document	Native American tribal document
U.S. Citizen ID Card (Form I-197)	Form I-197
Identification Card for use of Resident Citizen in the United States (Form I-179)	Form I-179
Employment authorization document issued by DHS (List C #7) (Note: This selection does not include the Employment Authorization Document (Form I-766) from List A.)	Employment Auth. document (DHS) List C #7
Receipt for the application to replace a lost, stolen or damaged Social Security Account Number Card without restrictions	Receipt: Replacement Unrestricted SS Card
Receipt for the application to replace a lost, stolen or damaged Original or certified copy of a U.S. birth certificate bearing an official seal	Receipt: Replacement Birth Certificate
Receipt for the application to replace a lost, stolen or damaged Native American Tribal Document	Receipt: Replacement Native American Tribal Doc.
Receipt for the application to replace a lost, stolen or damaged Employment Authorization Document issued by DHS	Receipt: Replacement Employment Auth. Doc. (DHS)

Issuing Authority: Enter the issuing authority of the List C document or receipt. The issuing authority is the entity that issued the document.

Document Number: Enter the document number, if any, of the List C document or receipt exactly as it appears on the document. If the document does not contain a number, enter N/A in this field.

Expiration Date (*if any*) (*mm/dd/yyyy*): Enter the expiration date, if any, of the List C document. The document is not acceptable if it has already expired, unless USCIS has extended the expiration date on the document. For instance, if a conditional resident presents a Form I-797 extending his or her conditional resident status with the employee's expired Form I-551, enter the future expiration date as indicated on the Form I-797. If the document has no expiration date, enter N/A in this field. For a receipt, enter the expiration date of the receipt validity period as described in the Receipt section above.

Additional Information: Use this space to notate any additional information required for Form I-9 such as:

- Employment authorization extensions for Temporary Protected Status beneficiaries, F-1 OPT STEM students, CAP-GAP, H-1B and H-2A employees continuing employment with the same employer or changing employers, and other nonimmigrant categories that may receive extensions of stay
- Additional document(s) that certain nonimmigrant employees may present
- Discrepancies that E-Verify employers must notate when participating in the IMAGE program
- Employee termination dates and form retention dates
- E-Verify case number, which may also be entered in the margin or attached as a separate sheet per E-Verify requirements and your chosen business process
- Any other comments or notations necessary for the employer's business process

You may leave this field blank if the employee's circumstances do not require additional notations.

Entering Information in the Employer Certification

Employee's First Day of Employment: Enter the employee's first day of employment as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy).

Signature of Employer or Authorized Representative: Review the form for accuracy and completeness. The person who physically examines the employee's original document(s) and completes Section 2 must sign his or her name in this field. If you used a form obtained from the USCIS website, you must print the form to sign your name in this field. By signing Section 2, you attest under penalty of perjury (28 U.S.C. § 1746) that you have physically examined the documents presented by the employee, the document(s) reasonably appear to be genuine and to relate to the employee named, that to the best of your knowledge the employee is authorized to work in the United States, that the information you entered in Section 2 is complete, true and correct to the best of your knowledge, and that you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing this form.

Today's Date: The person who signs Section 2 must enter the date he or she signed Section 2 in this field. Do not backdate this field. If you used a form obtained from the USCIS website, you must print the form to write the date in this field. Enter the date as a 2-digit month, 2-digit day and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Title of Employer or Authorized Representative: Enter the title, position or role of the person who physically examines the employee's original document(s), completes and signs Section 2.

Last Name of the Employer or Authorized Representative: Enter the full legal last name of the person who physically examines the employee's original documents, completes and signs Section 2. Last name refers to family name or surname. If the person has two last names or a hyphenated last name, include both names in this field.

First Name of the Employer or Authorized Representative: Enter the full legal first name of the person who physically examines the employee's original documents, completes, and signs Section 2. First name refers to the given name.

Employer's Business or Organization Name: Enter the name of the employer's business or organization in this field.

Employer's Business or Organization Address (*Street Name and Number*): Enter an actual, physical address of the employer. If your company has multiple locations, use the most appropriate address that identifies the location of the employer. Do not provide a P.O. Box address.

City or Town: Enter the city or town for the employer's business or organization address. If the location is not a city or town, you may enter the name of the village, county, township, reservation, etc, that applies.

State: Enter the two-character abbreviation of the state for the employer's business or organization address.

ZIP Code: Enter the 5-digit ZIP code for the employer's business or organization address.

Completing Section 3: Reverification and Rehires

Section 3 applies to both reverification and rehires. When completing this section, you must also complete the Last Name, First Name and Middle Initial fields in the Employee Info from Section 1 area at the top of Section 2, leaving the Citizenship/ Immigration Status field blank. When completing Section 3 in either a reverification or rehire situation, if the employee's name has changed, record the new name in Block A.

Reverification

Reverification in Section 3 must be completed prior to the earlier of:

- The expiration date, if any, of the employment authorization stated in Section 1, or
- The expiration date, if any, of the List A or List C employment authorization document recorded in Section 2 (with some exceptions listed below).

Some employees may have entered "N/A" in the expiration date field in Section 1 if they are aliens whose employment authorization does not expire, e.g. asylees, refugees, certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau. Reverification does not apply for such employees unless they choose to present evidence of employment authorization in Section 2 that contains an expiration date and requires reverification, such as Form I-766, Employment Authorization Document.

You should not reverify U.S. citizens and noncitizen nationals, or lawful permanent residents (including conditional residents) who presented a Permanent Resident Card (Form I-551). Reverification does not apply to List B documents.

For reverification, an employee must present an unexpired document(s) (or a receipt) from either List A or List C showing he or she is still authorized to work. You CANNOT require the employee to present a particular document from List A or List C. The employee is also not required to show the same type of document that he or she presented previously. See specific instructions on how to complete Section 3 below.

Rehires

If you rehire an employee within three years from the date that the Form I-9 was previously executed, you may either rely on the employee's previously executed Form I-9 or complete a new Form I-9.

If you choose to rely on a previously completed Form I-9, follow these guidelines.

- If the employee remains employment authorized as indicated on the previously executed Form I-9, the employee does not need to provide any additional documentation. Provide in Section 3 the employee's rehire date, any name changes if applicable, and sign and date the form.
- If the previously executed Form I-9 indicates that the employee's employment authorization from Section 1 or employment authorization documentation from Section 2 that is subject to reverification has expired, then reverification of employment authorization is required in Section 3 in addition to providing the rehire date. If the previously executed Form I-9 is not the current version of the form, you must complete Section 3 on the current version of the form.
- If you already used Section 3 of the employee's previously executed Form I-9, but are rehiring the employee within three years of the original execution of Form I-9, you may complete Section 3 on a new Form I-9 and attach it to the previously executed form.

Employees rehired after three years of original execution of the Form I-9 must complete a new Form I-9.

Complete each block in Section 3 as follows:

Block A - New Name: If an employee who is being reverified or rehired has also changed his or her name since originally completing Section 1 of this form, complete this block with the employee's new name. Enter only the part of the name that has changed, for example: if the employee changed only his or her last name, enter the last name in the Last Name field in this Block, then enter N/A in the First Name and Middle Initial fields. If the employee has not changed his or her name, enter N/A in each field of Block A.

Block B - Date of Rehire: Complete this block if you are rehiring an employee within three years of the date Form I-9 was originally executed. Enter the date of rehire in this field. Enter N/A in this field if the employee is not being rehired.

Block C - Complete this block if you are reverifying expiring or expired employment authorization or employment authorization documentation of a current or rehired employee. Enter the information from the List A or List C document(s) (or receipt) that the employee presented to reverify his or her employment authorization. All documents must be unexpired.

Document Title: Enter the title of the List A or C document (or receipt) the employee has presented to show continuing employment authorization in this field.

Document Number: Enter the document number, if any, of the document you entered in the Document Title field exactly as it appears on the document. Enter N/A if the document does not have a number.

Expiration Date (*if any*) (*mm/dd/yyyy*): Enter the expiration date, if any, of the document you entered in the Document Title field as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). If the document does not contain an expiration date, enter N/A in this field.

Signature of Employer or Authorized Representative: The person who completes Section 3 must sign in this field. If you used a form obtained from the USCIS website, you must print Section 3 of the form to sign your name in this field. By signing Section 3, you attest under penalty of perjury (28 U.S.C. §1746) that you have examined the documents presented by the employee, that the document(s) reasonably appear to be genuine and to relate to the employee named, that to the best of your knowledge the employee is authorized to work in the United States, that the information you entered in Section 3 is complete, true and correct to the best of your knowledge, and that you are aware that you may face severe penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing this form.

Today's Date: The person who completes Section 3 must enter the date Section 3 was completed and signed in this field. Do not backdate this field. If you used a form obtained from the USCIS website, you must print Section 3 of the form to enter the date in this field. Enter the date as a 2-digit month, 2-digit day, and 4-digit year (mm/dd/yyyy). For example, enter January 8, 2014 as 01/08/2014.

Name of Employer or Authorized Representative: The person who completed, signed and dated Section 3 must enter his or her name in this field.

What is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the "DHS Privacy Notice" below.

USCIS Forms and Information

For additional guidance about Form I-9, employers and employees should refer to the *Handbook for Employers: Guidance for Completing Form I-9 (M-274)* or USCIS' Form I-9 website at https://www.uscis.gov/i-9-central.

You can also obtain information about Form I-9 by e-mailing USCIS at I-9Central@dhs.gov, or by calling 1-888-464-4218 or 1-877-875-6028 (TTY).

You may download and obtain the English and Spanish versions of Form I-9, the *Handbook for Employers*, or the instructions to Form I-9 from the USCIS website at https://www.uscis.gov/i-9. To complete Form I-9 on a computer, you will need the latest version of Adobe Reader, which can be downloaded for free at http://get.adobe.com/reader/. You may order paper forms at https://www.uscis.gov/forms/forms-by-mail or by contacting the USCIS Contact Center at 1-800-375-5283 or 1-800-767-1833 (TTY).

Information about E-Verify, a web-based system that allows employers to confirm the eligibility of their employees to work in the United States, can be obtained at https://www.e-verify.gov or by contacting E-Verify at https://www.e-verify.gov/contact-us.

Employees with questions about Form I-9 and/or E-Verify can reach the USCIS employee hotline by calling 1-888-897-7781 or 1-877-875-6028 (TTY).

Photocopying Blank and Completed Forms I-9 and Retaining Completed Forms I-9

Employers may photocopy or print blank Forms I-9 for future use. All pages of the instructions and Lists of Acceptable Documents must be available, either in print or electronically, to all employees completing this form. Employers must retain each employee's completed Form I-9 for as long as the individual works for the employer and for a specified period after employment has ended. Employers are required to retain the pages of the form on which the employee and employer entered data. If copies of documentation presented by the employee are made, those copies must also be retained. Once the individual's employment ends, the employer must retain this form and attachments for either 3 years after the date of hire (i.e., first day of work for pay) or 1 year after the date employment ended, whichever is later. In the case of recruiters or referrers for a fee (only applicable to those that are agricultural associations, agricultural employers, or farm labor contractors), the retention period is 3 years after the date of hire (i.e., first day of work for pay).

Forms I-9 obtained from the USCIS website that are not printed and signed manually (by hand) are not considered complete. In the event of an inspection, retaining incomplete forms may make you subject to fines and penalties associated with incomplete forms.

Employers should ensure that information employees provide on Form I-9 is used only for Form I-9 purposes. Completed Forms I-9 and all accompanying documents should be stored in a safe, secure location.

Form I-9 may be generated, signed, and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR 274a.2.

DHS Privacy Notice

AUTHORITIES: The information requested on this form, and the associated documents, are collected under the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

PURPOSE: The primary purpose for providing the requested information on this form is for employers to verify your identity and employment authorization. Consistent with the requirements of the Immigration Reform and Control Act of 1986, employers use the Form I-9 to document the verification of the identity and employment authorization for new employees to prevent the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States. This form is completed by both the employer and employee, and is ultimately retained by the employer.

DISCLOSURE: The information you provide is voluntary. However, failure to provide the requested information, including your Social Security number (if applicable), and any requested evidence, may result in termination of employment. Failure of the employer to ensure proper completion of this form may result in the imposition of civil or criminal penalties against the employer. In addition, knowingly employing individuals who are not authorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an individual to work in the United States. The employer must retain this completed form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section. DHS may also share this information, as appropriate, for law enforcement purposes or in the interest of national security.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 35 minutes per response, when completing the form manually, and 26 minutes per response when using a computer to aid in completion of the form, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Avenue NW, Washington, DC 20529-2140; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Town of Merrimac

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
4 School St.	Merrimac	MA	01860

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

ESSEX REGIONAL RETIREMENT:

Your pension contributions are made through a payroll deduction. If you became a member after July 1, 1996 to present your contribution rate is 9%. Additionally, you also must contribute 2% of your annual pensionable income earned over $30,000.

- New Members **must** provide a copy of their birth certificate.
- If new member is a Veteran, he/she **must** provide a copy of Military Discharge.
- Beneficiary Form must be completed and signed by a witness **that is NOT a beneficiary**. Note that it is acceptable for the official administering the enrollment form at the time of hire witness the Beneficiary Selection Form.
- If you choose "Option D" on the beneficiary page, you **must** furnish a copy of the beneficiary's birth certificate or there may be a suspension of compensation.
- If you choose "Option D" and the beneficiary is your current or former spouse, you **must** provide a copy of your marriage certificate.

For questions regarding beneficiary benefit options, please contact Essex Regional Retirement Board at 978-739-9151 or 800-224-4804.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
New Member Enrollment

Form Last Revised: February, 2020

The *New Member Enrollment* Form allows a newly hired employee to apply for membership in a public retirement system. The form must be completed by any new employee regardless of his or her past employment with any governmental entity. Certain information on this form must be provided by the Payroll/Personnel Department and verified by the retirement board.

A new member must also complete the *Beneficiary Selection Form for Refund of Accumulated Deductions* and, if applicable, the *Beneficiary Selection Form (Option D)*.

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:	Essex Regional Retirement System		
Address:	491 Maple St. Suite 202		
City/Town:	Danvers	**Zip Code:**	01923-4025
Telephone:	978-739-9151	**Fax:**	

Employee Information

Employee Last Name:		**First Name:.**		**M.I.:**	
Social Security # (Entire #):		**Phone #:**		**Sex:**	
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Birth/Former Name *(if different)*			**Email:**		
Date of Birth*:		**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced***			
Spouse's Name:		**Spouse's DOB:**		**# of Children:**	

Your Retirement Board will request a copy of birth records, military discharge papers and other pertinent data.
***If Divorced and you have a Qualified Domestic Relations Order (QDRO), please attach a copy.**

Current/Prior Retirement System Membership

List prior or current public retirement system membership:

Are you retired from any other Massachusetts public retirement system? ☐ **YES** ☐ **NO**

Were you ever a member of any other Massachusetts public retirement system? ☐ **YES** ☐ **NO**

List prior or current public retirement system membership:

SYSTEM	DATES OF MEMBERSHIP From:	To:	ARE YOUR FUNDS STILL ON DEPOSIT?	
			☐ YES	☐ NO
			☐ YES	☐ NO
			☐ YES	☐ NO

If you wish to purchase past creditable service, please ask your Retirement Board about your options.

Did you ever work for or do you currently work for the Commonwealth or one of its political subdivisions for which you were not/are not a contributing member of a a retirement system? ☐ **YES** ☐ **NO**

Member Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Other Public Employment in Massachusetts

List prior or current public employment in Massachusetts or one of its political subdivisions (Non-membership):

EMPLOYER	DATES OF EMPLOYMENT	
	From:	To:

Veteran Status

Are you a veteran? ☐ YES ☐ NO

If **YES**, please enter dates of service and attach a copy of your military discharge papers, Forms DD-214, DD-215, DD-256, NGB 22, or NGB 22A.

DATES OF ACTIVE SERVICE	
From:	To:

I hereby authorize the Treasurer to withhold the proper percentage of my regular compensation due on each pay period and to deposit such deductions to my credit in the annuity savings fund. I understand the full amount of such deductions, with regular interest as provided by law, will be returned to me upon my written request if I terminate my service, unless I plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth or other conditions apply. In the event that I die before retiring, my named beneficiary or beneficiaries may receive survivor benefits **OR** a refund of my accumulated total deductions as allowed by law.

I sign this application under the penalties of perjury. I affirm that the information presented in this application is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of my benefits as well as civil and criminal penalties.

Applicant's Signature:

Print Employee's Name:

Employee's Signature: **Date:**

Member Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Payroll/Personnel Department

To be completed by Payroll/Personnel Department and verified by Retirement Board:

Check base rate to be deducted for retirement:

☐ 5% ☐ 7% ☐ 8% ☐ 9% ☐ Additional 2%

If 5%, 7%, or 8%, state reason:

Current Rate of Regular Compensation per Pay Period: $

Employment Status (Check ALL that apply):

☐ Permanent ☐ Temporary ☐ Full-time ☐ Part-time ☐ 50% ☐ 75% ☐ Other:

Agency/Dept: **Title/Position:**

Starting Date of Present Position:

Authorized Signature: **Date:**

Print Name:

Retirement Board

To be completed by Retirement Board:

Membership Date: **Annual Regular Compensation:** $

% to be Deducted **Current Group Classification:**

The member should also complete the *Beneficiary Selection Form (Refund)* or if applicable, the *Beneficiary Selection Form (Option D)*.

Essex Regional Retirement System

BENEFICIARY OPTIONS WHILE STILL A MEMBER

A member has options from which to choose in order to provide benefits to your survivors if you should pass prior to retirement. But you must complete a beneficiary form and submit it to the retirement system in order for your wishes to be followed. During your membership in the retirement system, you may change your beneficiary selection at any time by filing a new form.

If a member wishes to have a lump sum paid to a designated beneficiary or beneficiaries, they must complete the Beneficiary Selection Form. If the member has not designated an Option D beneficiary, the member's accumulated deductions will be paid in a lump sum to the beneficiary or beneficiaries based on the allocations provided on the Beneficiary Selection Form.

If a member wishes to have a monthly retirement benefit paid out to their beneficiary, they must fill out the Choice of Option D Beneficiary Form. Option D provides a monthly benefit that a beneficiary would have received under Option C had the member retired on the date of death. If the member is under age 55, the member's age is "bumped up" to age 55 under Option D. (For members joining after April 2, 2012, the age is "bumped up" to 60.) A member can designate an Option D beneficiary at any time. Only a spouse, former spouse who has not remarried, child, mother, father, brother or sister is eligible to be designated as an Option D beneficiary.

The Option D beneficiary must receive the survivor benefit allowance.

If a member does not make an Option D designation, the member's spouse can still elect to receive the Option D allowance, or can request a return of the member's accumulated retirement deductions, provided that the member must have completed at least two years of creditable service; the member and spouse must have been married for at least one year; the member and spouse must have been living together at the time of death; and if the member and spouse were not living together at the time of death, the Board must find that they were living apart for justifiable cause.

The rights of a eligible surviving spouse will always supersede any other person nominated as the Option D beneficiary. The eligible spouse will have 90 days from the date of notification from the retirement board to elect the Option D benefit.

The selection of Option D beneficiary has a serious and lasting legal implications and we strongly recommend members speak with an ERRS retirement counselor when determining which beneficiary option to select. Our retirement counselors can be reached during regular office hours, which are Monday through Friday from 8:30 a.m. to 4:30 p.m., and the phone number is (978) 739-9151.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
Beneficiary Selection Form for Refund of Accumulated Deductions
(If Member Dies Before Retirement)
Pursuant to Massachusetts General Laws, Chapter 32, Section 11(2)(c)

Form Last Revised: February, 2020

The *Beneficiary Selection Form for Refund of Accumulated Deductions* allows a member to select a beneficiary or beneficiaries to receive payment of accumulated deductions and other payments due a member if the member dies before retirement, as described at Massachusetts General Laws, Chapter 32, Section 11(2)(c).

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you have designated an eligible beneficiary who is alive at the time of your death on the *Beneficiary Selection Form for Option D*, then the money in your annuity account will not be disbursed to anyone in a one-time lump-sum payment, even if you have designated them on this form.
- Any person or entity may be designated as your Refund of Accumulated Deductions beneficiary under Section 11(2)(c). You may designate multiple beneficiaries and must indicate the percentage of the annuity account that you wish each beneficiary to receive. The percentages must total 100%.
- Your selection of a beneficiary on this form also may be superseded by an eligible spouse under the provisions of Option D.
- If your personal situation changes (e.g. divorce, a domestic relations order goes into effect, your beneficiary dies), you should file a new form with your retirement board.
- If you file a new Section 11(2)(c) form with your retirement board, it will supersede any and all prior Section 11(2)(c) forms filed previously by you.
- When you sign this form, it should be witnessed by a disinterested party.
- This form becomes void upon your retirement.

Beneficiary Selection Form for Refund of Accumulated Deductions
(If Member Dies Before Retirement)
Pursuant to Massachusetts General Laws, Chapter 32, Section 11(2)(c)

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:	Essex Regional Retirement Board Essex Regional Retirement System		
Address:	491 Maple St. Suite 202 491 Maple Street Building 202		
City/Town:	Danvers Danvers	**Zip Code:**	01923 01923-4025
Telephone:	(978) 739-9151 (978) 739-9151	**Fax:**	(978) 750-0745

Member's Information:

Member's Last Name	Member's First Name	Social Security # (last four)
		***-**-____ ____ ____ ____

Street Address:					
City/Town:		**State:**		**Zip Code:**	
Email:					
Phone:					

Choice of Beneficiary or Beneficiaries to Receive a Refund of Accumulated Total Deductions at Member's Death:

- Any person or entity may be a beneficiary under Massachusetts General Laws, Chapter 32, Section 11(2)(c). Give complete name and address of each beneficiary on the next page.

I, (Print Name) _____, a member of the _____ Retirement System hereby request the Retirement Board to pay any sum referred to in Massachusetts General Laws, Chapter 32, Section 11(2)(c) due at my death to the following beneficiary or beneficiaries in the proportions designated on the next pages.

Member Last Name:		**First Name:**		**SSN:**	***-**-__ __ __ __

PRIMARY LUMP-SUM BENEFICIARY(IES)

Do NOT name any one person or entity as a beneficiary more than ONCE in this section.

Primary Lump-Sum Beneficiary Information:

						% of Benefit**
Full Name: (First, MI, Last):				**SSN/EIN*:**		
Relationship to You:		**Phone:**		**Date of Birth:**		
Address:						
Full Name: (First, MI, Last):				**SSN/EIN*:**		
Relationship to You:		**Phone:**		**Date of Birth:**		
Address:						
Full Name: (First, MI, Last):				**SSN/EIN*:**		
Relationship to You:		**Phone:**		**Date of Birth:**		
Address:						
Full Name: (First, MI, Last):				**SSN/EIN*:**		
Relationship to You:		**Phone:**		**Date of Birth:**		
Address:						
Full Name: (First, MI, Last):				**SSN/EIN*:**		
Relationship to You:		**Phone:**		**Date of Birth:**		
Address:						
						0%

*Beneficiary's full Social Security Number (SSN) or Employer Identification Number (EIN), if an organization.
**Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficaries.

CONTINGENT LUMP-SUM BENEFICIARY(IES)

In the event that none of the named primary lump-sum beneficiary(ies) above, are alive, or, if an organization, still operating, as of your death.

Contingent Lump-Sum Beneficiary Information:

						% of Benefit**
Full Name: (First, MI, Last):				**SSN/EIN*:**		
Relationship to You:		**Phone:**		**Date of Birth:**		
Address:						
Full Name: (First, MI, Last):				**SSN/EIN*:**		
Relationship to You:		**Phone:**		**Date of Birth:**		
Address:						
Full Name: (First, MI, Last):				**SSN/EIN*:**		
Relationship to You:		**Phone:**		**Date of Birth:**		
Address:						
Full Name: (First, MI, Last):				**SSN/EIN*:**		
Relationship to You:		**Phone:**		**Date of Birth:**		
Address:						
Full Name: (First, MI, Last):				**SSN/EIN*:**		
Relationship to You:		**Phone:**		**Date of Birth:**		
Address:						
						0%

*Beneficiary's full Social Security Number (SSN) or Employer Identification Number (EIN), if an organization.
**Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficaries.

Beneficiary Selection Form for Refund of Accumulated Deductions

Member Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

I understand that my selection may be superseded if I die with an eligible beneficiary under Option D.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement, this form becomes void.

The types of payments covered under Massachusetts General Laws, Chapter 32, Section 11(2)(c) include:

- The one-time payment of the accumulated deductions credited to a member's account in the annuity savings fund at the date of death when the member's death occurs prior to his/her retirement.
- Any amounts payable to a member at his or her death.

Member's Signature:

Print Name:

Signature: **Date:**

To Be Completed By Witness (should be disinterested party):

Name (Print):

Street Address:

City/Town: **State:** **Zip Code:**

Signature: **Date:**

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction

Beneficiary Selection Form - Option D (If Member Dies Before Retirement)

Pursuant to Massachusetts General Laws, Chapter 32, Section 12(2)(d)

Form Last Revised: February, 2020

The *Beneficiary Selection Form - Option D* allows a member to select an eligible beneficiary to receive an allowance if the member dies before retirement. This is the Member Survivor allowance described at Massachusetts General Laws, Chapter 32, Section 12(2)(d) ("Option D").

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you designate an eligible beneficiary on this form, and that beneficiary is living at the time of your death, the money in your annuity account will not be disbursed to anyone in a one-time, lump-sum payment, even if you have named them to receive such money on your *Beneficiary Selection Form for Refund of Accumulated Deductions*.
- You may name only one person as the Option D beneficiary. That one person may be your spouse, your former spouse who is not remarried at the time of your death, your child, your father, your mother, your sister or your brother.
- If you select a beneficiary other than the spouse to whom you are married at the time of your death, your selection on this form may be superseded by the eligible spouse under the provisions of Option D if you die before retirement.
- If your personal situation changes (e.g. divorce, a domestic relations order goes into effect, your beneficiary dies), you should file a new form with your retirement board.
- If you file a new Option D form with your retirement board, it will supersede any and all prior Option D forms previously filed by you.
- When you sign this form, it should be witnessed by a disinterested party.
- To cancel an Option D beneficiary designation prior to retirement, your written notice must be filed with the retirement board.
- This form becomes void upon your retirement.

Beneficiary Selection Form - Option D (If Member Dies Before Retirement)

Pursuant to Massachusetts General Laws, Chapter 32, Section 12(2)(d)

Form Last Revised: July, 2019

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:	Essex Regional Retirement Board		
Address:	491 Maple Street, Building 200		
City/Town:	Danvers	**Zip Code:**	01923
Telephone:	(978) 739-9151	**Fax:**	(978) 750-0745

Member's Information:

Member's Last Name	**Member's First Name**	**Social Security # (last four)**
		***-**-____ ____ ____ ____

Street Address:					
City/Town:		**State:**		**Zip Code:**	
Email:					
Phone:					

Choice of Option D Beneficiary

I, (Print Name) _____, a member of the _____ Retirement System, hereby nominate the beneficiary listed below, under the provisions of Massachusetts General Laws, Chapter 32, Section 12(2)(d) to receive from the retirement system a benefit equal to the Option C retirement allowance which would otherwise have been payable to me, in the event that I die before being retired.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement this form becomes void.

I understand that this choice of Option D Beneficiary can be superceded if, at my death, I have at least two years of creditable service and leave a spouse to whom I have been married for over one year and with whom I am living on the date of my death, or if living apart, doing so for justifiable cause as determined by the Retirement Board.

Beneficiary

This person is my: ☐ Parent ☐ Sibling ☐ Unmarried Former Spouse* ☐ Spouse* ☐ Child

Name of Eligible Beneficiary:					
Beneficiary's Date of Birth: *(attach birth record)*		**Beneficiary's Social Security #:**			
Beneficiary's Street Address:					
City/Town:		**State:**		**Zip Code:**	

*If beneficiary is your spouse or former spouse, a copy of your marriage certificate is required

Member's Signature:

Print Name:			
Signature:		**Date:**	

To Be Completed By Witness (should be disinterested party):

Print Name:					
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Signature:		**Date:**			

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy

Employee Health Insurance Responsibility Disclosure Form

You are completing this form because you have declined to participate in your employer sponsored health insurance plan and/or have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement. A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis. For information about affordable health insurance options, visit the Commonwealth Connector at < www.mahealthconnector.org >.

Employer

Employers: please complete this section. See reverse side for instructions.

Employer Name: Town of Merrimac **FEIN:** 046-001-219

Employer D/B/A:

Employer Address: 4 School Street

City | State | ZIP Code: Merrimac, MA 01860

1. Did you offer a "Section 125 Cafeteria Plan" to this employee? Yes ☐ No ☐
2. Did you offer employer sponsored health insurance to this employee? Yes ☐ No ☐
3. If you offered sponsored insurance to this employee, what is the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee? (If did not offer sponsored insurance, leave blank.) $

Employee

Employees: please complete this section. See reverse side for instructions.

Employee First Name **Middle Initial**

Employee Last Name **Suffix** (e.g., Sr., Jr.)

1. Did you accept your employer sponsored health insurance? Yes ☐ No ☐ None Offered ☐
2. Did you agree to use your employer's "Section 125 Cafeteria Plan" to purchase health insurance? Yes ☐ No ☐ None Offered ☐
3. Do you have other health insurance? Yes ☐ No ☐

Employee Affidavit

I hereby affirm, under penalties of perjury, that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment, that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to M.G.L c. 111M, that the Employee Health Insurance Responsibility Disclosure (HIRD) Form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed HIRD Form.

Employee Signature **Date (MM/DD/YY)** / /

The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Department of Revenue as required by state regulation 114.5 CMR 18.00.

Instructions

Employer Information

Employer Name
Employers must enter the company's legal name.

FEIN
The employer must enter the Federal Employer Identification Number.

D/B/A
The employer must enter the company's trade name "Doing Business As" here, if applicable.

Employer Address
The employer must enter the business address including city, state, and ZIP Code.

Question 1
The employer must indicate either Yes or No (check box).

Question 2
The employer must indicate either Yes or No (check box).

Question 3
The employer must report the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee, if the employer offers a sponsored health plan (i.e. the employer offers to pay for a portion of the premium).

Employee Information

Employee First Name
The employee or employer must enter the employee's first name.

Employee Last Name
The employee or employer must enter the employee's last name.

Question 1
The employee must indicate Yes, No, or None Offered if health insurance is not offered (check box).

Question 2
The employee must indicate Yes, No, or None Offered if a "Section 125 Cafeteria Plan" is not offered (check box).

Question 3
The employee must indicate Yes or No (check box).

Employee Signature
The employee must sign and date the Employee Health Insurance Responsibility Disclosure (HIRD) form.

Note to Employer Regarding Employee Signature
If the employee refuses to sign and date the form, the refusal should be noted in writing and signed by the authorized company representative (e.g., the owner, supervisor or manager, chief executive officer, etc.).

Alternate Versions of This Form

Employers may recreate their own version of the Employee Health Insurance Responsibility Disclosure (HIRD) form. However, all information must be included, with the same wording and order, and the sequence and numbering of the Questions must be exactly as it appears on the version provided by the Commonwealth of Massachusetts.

EMPLOYER CAFETERIA PLAN
SALARY REDIRECTION/REDUCTION AGREEMENT

EMPLOYER: TOWN OF MERRIMAC

EMPLOYER'S TAX ID NUMBER: 04 - 6001219

AFFILIATE'S NAME/LOCATION: _____

AFFILIATE'S TAX ID NUMBER: _____ - _____

CAFETERIA PLAN YEAR: FY ___/___/___ – ___/___/___

(CHECK ONE) ☐ OPEN ENROLLMENT OR ☐ NEWLY ELIGIBLE EMPLOYEE, ELIGIBILITY DATE: ___/___/___

SOCIAL SECURITY NO.: _____ DATE OF BIRTH: ___/___/___ PHONE: (___)_____

NAME: (Last) _____ (First) _____ (Middle Initial)_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL: _____

No. of Payroll Cycles in Plan Year: _____ Date of First Deduction: ___/___/___ Payroll Mode: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution will be deducted from my paycheck by my employer or a third-party payroll administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. Amounts corresponding to employer-provided, nonelective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Cafeteria Plan as elected in the Pre-Tax column below. Any previous election and Salary Redirection Agreement under the Cafeteria Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of any premium/ contribution amounts hereunder shall evidence acceptance of this agreement.

Check the desired coverage(s) below. (Note: If this is an annual enrollment, your existing coverage elections will remain the same (as adjusted for any increase/decrease in premium or required contribution) except as indicated below.)

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage	_____	_____	Specified Health Event Insurance	_____	_____
Dental Insurance	_____	_____	Short-Term Disability Insurance	_____	_____
Vision Insurance	_____	_____	Long-Term Disability Insurance	_____	_____
Cancer Insurance	_____	_____	Hospital Confinement Indemnity Insurance	_____	_____
Hospital Intensive Care Insurance	_____	_____	Personal Sickness Indemnity Insurance	_____	_____
Accident Insurance	_____	_____	Health Savings Account (HSA) §223	_____	_____
Group Term Life Insurance (if family, must be after-tax)	_____	_____	Other accident or health plan(s) under Section 106 of the Internal Revenue Service Code	_____	_____
			List: _____		

Required acknowledgment to participate in Cafeteria Plan:

I certify that the features and benefits under the Cafeteria Plan have been explained to me completely. By initialing, I acknowledge that I understand the Important Information Regarding Participation in the Cafeteria Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Cafeteria Plan.

INITIAL

WAIVER OF PRE-TAX BENEFITS UNDER THE CAFETERIA PLAN:

I elect to waive all pre-tax benefits under the Cafeteria Plan. Except for a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

INITIAL

EMPLOYEE'S SIGNATURE: _____ **DATE:** _____

IMPORTANT INFORMATION REGARDING PARTICIPATION IN THE FLEXIBLE BENEFITS PLAN

I understand and agree to the following:

- **Restrictions on Election Changes:** On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next anniversary date of the plan unless a change in status occurs (as defined under the plan and the Internal Revenue Code), and the change is caused by and consistent with the change in status.

- **Commencement of Coverage and Status of Prior Elections:** Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or insurance policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop, or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue.

- **Use of Personal Information:** In addition to and without limiting in any way the rights my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status, and health and dependent child care information) as is reasonably required to administer the plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure, or release of such information so long as the information is used in furtherance of plan administration, or to detect or prevent fraud or misrepresentation.

- **Effect of Pre-Tax Contributions on Benefits Payments:** Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverages may be funded on an after-tax basis to preserve the excludability of policy benefits.

- **PLAN DOCUMENT CONTROLS:** I verify that I have received a summary of the tax rules, operational guidelines, and procedures for use with the Cafeteria Plan. I understand that the plan document will control notwithstanding any contrary oral representation by any person.

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name Town of Merrimac **Employer ID#** 046-001-219

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, “Windfall Elimination Provision.”

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, “Government Pension Offset.”

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x700**

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

2518-1 — Group Number-Division Number

Town of Merrimac — Employer/Policyholder

Dept. ID

Employee Name *(Last, First, Middle)*

Social Security Number

Home Address *(Street, City, State, Zip)*

( ) Telephone #

Gender *(M/F)* | Occupation or Job Title | Date of Birth | Age

PAYROLL TYPE: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Annual Earnings: $

Average Hours Worked | Date of Hire | or Date of Full Time Employment if different | Effective Date | State | Class | Rate Basis

Spouse *(Last, First, Middle)* | Gender *(M/F)* | Date of Birth | Age | No. of Dependents

LIFE - DISABILITY

ONLY ELECT BOSTON MUTUAL COVERAGES MADE AVAILABLE TO YOU THROUGH YOUR EMPLOYER.

BASIC	YES	NO	Insurance Amount
LIFE	❑	❑	$
AD&D	❑	❑	$
DEPENDENT LIFE:			
SPOUSE	❑	❑	$
CHILD(REN)	❑	❑	$
SHORT TERM DISABILITY	❑	❑	$
LONG TERM DISABILITY	❑	❑	$
❑ OTHER *(Please specify coverage & amt.)*			

VOLUNTARY	YES	NO	Insurance Amount
LIFE	❑	❑	$
AD&D	❑	❑	$
DEPENDENT LIFE:			
SPOUSE LIFE AND AD&D	❑	❑	$
CHILD(REN)	❑	❑	$
SHORT TERM DISABILITY	❑	❑	$
LONG TERM DISABILITY	❑	❑	$
❑ OTHER *(Please specify coverage & amt.)*			

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS: ***(Attach Additional Beneficiaries on a signed and dated separate sheet)***

Primary Beneficiary(ies):	Residential Address	Date of Birth	Social Security #	Tel. #	Relationship	% of Benefit
Contingent Beneficiary(ies):						

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

Please complete as much beneficiary information as you can provide.

SIGNATURE

REFUSAL OF INSURANCE

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer *(or the Association with whom I am affiliated)* and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

❑ All Coverages ❑ Life & AD&D ❑ Dependent Coverage ❑ Short Term Disability ❑ Long Term Disability

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage(s) checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

EMPLOYEE SIGNATURE REQUIRED

I apply for the insurance for which I am now eligible *(or for which I may become eligible)* under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. *I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.* I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

NOTICE: READ BEFORE SIGNING ENROLLMENT FORM

BOSTON MUTUAL LIFE INSURANCE COMPANY REQUIRED FRAUD NOTICES
For use with Application Forms

STANDARD NOTICE:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to California residents:
For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Residents:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to DC Residents:
Warning: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by an applicant.

Notice to Florida Residents:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Maine Residents:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefit.

Notice to New Jersey Residents:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oklahoma Residents:
Any person who knowingly and with intent to injure, defraud or deceive any insurers, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Residents:
Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Notice to Puerto Rico:
Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years, if mitigating circumstances prevail, it may be reduced to a minimum of two (2) years.

Notice to Vermont:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to criminal and civil penalties.

Notice to Virginia Residents:
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Notice to Washington:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. The penalties include imprisonment, fines, and denial of insurance benefits.

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 ROYALL STREET · CANTON, MASSACHUSETTS 02021 · 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

(This authorization complies with the HIPAA Privacy Rule)

Name of *(Proposed)* Insured/Patient *(please print)* — Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(please print)* — Date of Birth ___/___/___

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *("Providers")* that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.** This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes.**

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. **I understand that I have the right to revoke this authorization in writing,** at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative — Date

Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant/Patient

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative — Date

Description of Personal Representative's Authority or Relationship to Second Proposed Insured/Claimant/Patient

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____ , the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured — Date

BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x 700**

Please refer to your Administration Kit for enrollment and mailing instructions

REFUSAL OF INSURANCE

Employee Name *(Last, First, Middle)* | Employer/Policyholder | Group No.

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer (or the Association with whom I am affiliated) and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

☐ All Coverages ☐ Life & AD&D ☐ Dependent Coverage ☐ STD ☐ LTD ☐ Dental ☐ Vision

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company. If I desire to participate in the dental program at a later date, additional benefit type waiting periods may apply.

Signature of Employee _____ SSN # _____

Signature of Witness _____ Date _____

Pregnant Workers Fairness Act

On July 27, 2017, "An Act Establishing the Massachusetts Pregnant Workers Fairness Act" was signed into law. The Act prohibits workplace and hiring discrimination related to pregnancy, childbirth, or a related condition, including, but not limited to, lactation or the need to express breast milk for a nursing child. The law further requires employers to provide reasonable accommodations in the workplace for expectant and new mothers. It is the [City/Town]'s policy to comply with the provisions of the Pregnant Workers Fairness Act, including the provision of reasonable accommodations when appropriate.

Under the Act, Town of Merrimac employees have a right to be free from discrimination based upon pregnancy or a condition related to pregnancy. The Town of Merrimac shall not take any adverse action against an employee on the basis of pregnancy or related medical condition, or for requesting or using an accommodation for pregnancy or related medical condition.

Examples of adverse actions include: denying employment opportunities based on pregnancy or related conditions; requiring an employee who is pregnant or has a pregnancy related medical condition to accept an accommodation that the employee chooses not to accept; requiring an employee to take leave if other reasonable accommodation can be provided without undue hardship; making pre-employment inquiry of a job applicant related to pregnancy, childbirth, or a related condition; and, when the need for a reasonable accommodation ceases, failing to reinstate the employee to the original employment status or to an equivalent position with equivalent pay and accumulated seniority, retirement, fringe benefits and other applicable service credits.

Reasonable Accommodations:

An employee working for the Town of Merrimac has a right to reasonable accommodation with respect to pregnancy and/or any condition resulting from pregnancy, so that the employee may perform the essential functions of the job, unless the requested accommodation will cause an undue hardship on the Town of Merrimac.

These accommodations can include, for example: frequent or longer paid or unpaid breaks; time off to recover from childbirth or complications from pregnancy, with or without pay; acquisition or modification of equipment or seating; temporary transfer to a less strenuous or hazardous position; job restructuring and/or modified work schedule; light duty and/or assistance with manual labor; and private non-bathroom space for expressing breast milk.

The Town of Merrimac may request documentation from the employee's health care provider(s) about the need for a reasonable accommodation, except in the cases of requests for: more frequent restroom, food or water breaks; seating; limits on lifting more than 20 pounds; and private non-bathroom space for expressing breast milk.

Contact Carol McLeod with questions about, or requests for reasonable accommodation under, the Pregnant Workers Fairness Act.

TOWN OF MERRIMAC

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

To enroll in Direct Deposit, simply fill out his form and give it to your Payroll Department. Attach a voided check for each checking account. If depositing to a savings account, ask your bank to give you the routing/transit number for your account. (It isn't always the same as the number on your deposit slip.) This will ensure that you are paid correctly.

Employee Name _____ **Social Security #** ___-__-____

ACCOUNT INFORMATION

1. Bank Name/City/State: _____
   Routing/Transit # _____ Account # _____
   ☐ Checking ☐ Savings Amount $ ____.__ or __Entire Net

2. Bank Name/City/State: _____
   Routing/Transit # _____ Account # _____
   ☐ Checking ☐ Savings Amount $ ____.__ or __Entire Net

3. Bank Name/City/State: _____
   Routing/Transit # _____ Account # _____
   ☐ Checking ☐ Savings Amount $ ____.__ or __Entire Net

4. Bank Name/City/State: _____
   Routing/Transit # _____ Account # _____
   ☐ Checking ☐ Savings Amount $ ____.__ or __Entire Net

5. Bank Name/City/State: _____
   Routing/Transit # _____ Account # _____
   ☐ Checking ☐ Savings Amount $ ____.__ or __Entire Net

I hereby authorize the Town of Merrimac to deposit any amounts owed me by initiating credit entries to my accounts indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by the Town of Merrimac to my accounts. In the event that the Town of Merrimac deposits funds erroneously into my account, I authorize the Town of Merrimac to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until the Town of Merrimac and Bank have received written notice from me of its termination in such manner as to afford the Town of Merrimac and Bank reasonable opportunity to act on it.

EMPLOYEE SIGNATURE: _____ **DATE:** __/__/____